HOPSPITALS & AMBULATORY CLINICS - 2004
SUMMARY OF JCAHO REQUIREMENTS FOR IMPROVEMENTS

ETHICS, RIGHTS, AND RESPONSIBILITIES (RI)

PROVISION OF CARE, TREATMENT, AND SERVICES (PC)

Assessment

PC.2.10 – At one MTF, on two individual tracers, nutritional issues were identified. An adult patient being treated for substance abuse indicates that he lost ten pounds in a week. The documentation in the record of an adolescent mental health patient indicates that the patient is underweight. In both of these cases, further assessment of nutritional risk is not evident in the record. A recent record of a client admitted more recently indicated a more in-depth nutritional assessment, but the staff report that this process was only instituted in July 2003, and continues to be implemented.

PC.2.120 – At one MTF, the rules and regulations of the medical Staff in section A2.D.2 state that an H&P for a patient previously admitted is good for 30 days and that if the patient is readmitted, an interim progress note is required. For elective surgical patients the H&P may be completed up to 30 days prior to the scheduled surgery. However, an interim updated assessment is not required and none were noted in surgical patient tracers carried out. This was corrected in a special meeting of the MEC during the survey.

Additional Standard for Victims of Abuse

PC3.10 – At one MTF, during individual tracer activity on the MedSurg unit, it was noted that the nursing administration assessment does not include documentation to identify victims of abuse. No patients admitted directly to this unit are screened for abuse. Leadership stated that the form was changed and had included these criteria in the past. A stamp was developed and ordered during survey to include assessment for abuse in the nursing admission assessment.

Planning Care, Treatment, and Services

PC.4.20 – At one MTF, in three records of clients seen for mental health treatment, the care plans are not comprehensive. The plans contain broad goals with no specific objectives. The interventions are also broad: Individual, group therapy and/or medication evaluation. There are no time lines for expected achievement of goals. Identified symptoms, such as sleep disturbances, suicide ideation, homicide ideation, are not addressed on the plans. In one record of a client being treated for substance abuse, medical issues identified in treatment (weight loss, hepatitis A) were not identified on the plan.

PC.4.40 – At one MTF, the treatment plans reviewed during tracer activity of patients involved in a number of services such as Primary Health, Addiction, Family Advocacy, and Mental Health did not have clearly defined problems and needs statements that were based on the assessment. There was not a coordinated approach these complex patients and the various systems they were using. In additions there was no justification documented when needs were addressed and services were not provided.

Providing Care, Treatment, and Services

PC.5.50 – At one MTF, mechanisms to coordinate care provided by behavioral health services with primary and specialty care are limited to physician access to CHCS. Given limitations on psychiatrist time mechanisms for broader coordination of care need to be developed.

Availability of Resuscitation Services

PC.9.30 – At one MTF, following a patient tracer, staff interview, leadership sessions, medications management tracer, tour observations, and the competency assessment session, it was noted that not all staff identified by the hospital policy and job description were trained to recognize and respond to pediatric emergencies. Two ICU nurse files were reviewed which showed a lack of documentation of pediatric emergency resuscitation skills. A nurse who cared for pediatric patients on the medical-surgical floor did not have documented evidence of ongoing required training. Nurses on the medical-surgical floor could not quickly locate the Braslow tape. There were at least two different medication charts to be

used by residents for medication administration during pediatric codes. There were no dosing charts available in the c-section room.

Behavioral Health Care Restraint and Seclusion

PC.12.30 – At one MTF, following a patient tracer, staff interview, and review of three competency records of individuals who provided direct care to behavioral health patients, it was noted that there had been no ongoing training and demonstration of competency in physical holding techniques and takedown procedures. In addition, these same individuals had not received ongoing training and demonstration of the underlying causes of threatening behaviors, aggressive behavior related to the patient's medical condition, how staff behaviors can affect the behaviors of the patients and how to recognize signs of physical distress in patients who are being held or restrained. The same three individuals had not received ongoing training in and demonstration of competency in interpreting vital signs relevance to the physical safety of the patient in restraint.

PC.12.40 – At one MTF, following a patient tracer interview with staff on the behavioral unit, it was noted that the hospital did not have a process in place to determine if the patient has a behavioral health advance directive.

MEDICATION MANAGEMENT (MM)

Storage

MM.2.20 – At one MTF, there were three separate instances where single-use injectable vials had been opened and not disposed of, increasing the risk that these injectable medications may be reused (as multiple dose vials) PPD tuberculin testing medium had not been dated for disposal within 30 days as required by manufacturers guidelines.

Ordering and Transcribing

MM.3.20 – At one MTF, it was noted that in printed standard orders in the surgical suite, the dosages (concentrations) of two drugs was not indicated. For example: versed 10 IV, and KCI 20, i.e. no milligrams or milliequivalents evident This was a typographical error on the forms which had not been noticed and the forms had been in use for an indeterminate period of time. New, corrected forms were produced during the survey.

MM.3.20 – At another MTF, review of two open records of patients during individual tracers indicated that orders were not complete. Specifically, an order for morphine did not reflect the complete medication name; an IV medication for Flagyl did not reflect the rate to run the IV and order and order for Stadol did not state the route. The policy did not reflect required elements of an inpatient medication order.

Preparing and Dispensing

MM.4.10 – At one MTF, review of two inpatient medical records during individual tracers indicated that orders were not clarified when orders were incomplete, or used unapproved abbreviations.

MM.4.10 – At another MTF, following a patient tracer and interview with staff, it was noted that respiratory therapists are administering medications in the pulmonary function testing without a pharmacist review. In the CT area, radiology technicians are allowed to inject contrast media without pharmacy review of the medications. I neither of these cases were the situations urgent, nor was an LIP directly in control. These situations reflect a lack of good process design, particularly related to patient safety.

MM.4.40 – At one MTF, following tour observations, staff interview, and credentialing and privileging session, it was noted that the Physician Assistant at the Ft. McClellan clinic was transferring medications from large bulk containers to smaller bottles for dispensing to patients. The PA did not have any documentation of training to repackage medications. There had been no pharmacy oversight for this repackaging. It was unclear if this met Alabama state drug requirements.

MM.4.80 – At one MTF, review of controlled medications utilized by anesthesia staff indicated the process as designed is not being implemented consistently. Specifically, review of an anesthesia record and the corresponding log reflected a discrepancy in the amount of fentanyl utilized.

A review of reconciliation records for controlled substances used in the emergency room during the past 30 days, revealed that (in five instances where products had been wasted, including injectable meperidine and morphine sulphate) this oversight had not been documents in accordance with organization policy. During a tracer of a patient through he operating room, a review of controlled substances utilization was made. Anesthesiologists and CRNA's draw narcotics and related substances from a locked cabinet on a case by case basis as to perceived need. Wastage of unused portions is recorded and witnessed on the anesthesia worksheet. The pharmacy does not review anesthesia records and thus does not have a complete view of controlled substance wastage.

MM.4.80 – At another MTF, following two patient tracers and interviews with staff, it was found that drugs are administered from stock medications, e.g. Tylenol, Motrin, supplies kept on the nursing unit. At the Ft McClellan Troop Medical Clinic medications are dispensed from large amounts of stock medications. There was no monitoring to account for t unused drugs. There was not a consistent process in place to audit the medications removed to ensure that drugs used were for patient use. This situation reflects a lack of good process design, particularly related to patient safety.

IMPROVING ORGANIZATION PERFORMANCE (PI)

Data Collection

PI.1.10 – At one MTF, the urgent care unit indicated they averaged about four codes a month. In discussion as to the monitoring of the outcomes of resuscitation the staff indicated they had not been evaluating the outcomes based on organization requirements. After further discussions with a member of the Critical Care Committee it was identified the current forms and education to the staff were not available at this site.

Aggregation/Analysis

PI.2.10 – At one MTF, while the organization does collect data on a variety of indicators, there is limited use of statistical tools to aggregate, analyze and display data.

LEADERSHIP (LD)

Integrating/Coordinating Service

LD.3.30 – At one MTF, Responses to requests for inpatient consultation did not appear to be timely in physical rehabilitation, one of the bulleted essential services included in this element of performance. A physical therapy, (PT) staff member stated that the department's benchmark for responding to requests for inpatient consultations was 72 hours. The unit staff on the 4W medical-surgical unit stated that average length of stay on that unit was 2.5 days. An individual patient tracer identified a patient for whom PT consultation for participation in wound management had been requested 24 hours earlier. The patient had not been evaluated by PT at the time of the tracer. Staffing and workload requirements were reported to cause outpatient care to take precedence over inpatient consultation in that important clinical service.

Planning and Design of Svc.

LD.3.70 – At one MTF, there are 4-5 unfilled positions in Behavioral Health services. In addition, the psychiatrist is able only to function largely in a consultative and supervisory role. Additional psychiatry resources are necessary to address the demand for direct clinical services.

LD.3.90 – At one MTF, in one instance, policies and procedures that guided and supported patient care did not appear to meet two of the five elements of good process design. During an individual patient tracer of an active duty member a delay was noted of five hours, forty minutes from the decision to admit him from a clinic for IV antibiotic therapy and the time he received his first dose of antibiotics. This patient was seen in podiatry Clinic an 0820 hours, orders for admission written at 100. He arrived on the inpatient unit at 1300, and received the initial dose of antibiotics at 1540. The process design for this type of admission appeared to be inconsistent with the organization's values and goals, and it did not optimally meet the need of at least one individual served.

LD.5.80 – At one MTF, numerous Clinical Practice Guidelines have been identified and implemented by the organization. At the time of the survey clear identification of the clinical outcomes to be measured has not been identified for all guidelines.

MANAGEMENT OF THE ENVIRONMENT OF CARE (EC)

Planning and Implementation Activities

EC.1.10 – At one MTF, during the hospital tour it was noted tat four eyewash stations in four different locations were expired. The tag stated that the solution needed to be replaced six months after installation. Leadership clarified that this was the procedure. An oxygen e-cylinder in the oxygen storage room was not secured properly. Hydrogen peroxide used for cleaning equipment was stored under the sink in the dirty utility room on the MedSurg unit. The solution expired 4/04.

EC.5.40 – At one MTF, smoke/fire dampers number about one hundred forty throughout the hospital; approximately twenty of these have not been operated as required by life safety code. Although some of these devices may be almost impossible to operate due to locale, the hospital should redouble efforts to reduce this number to an absolute minimum.

MANAGEMENT OF HUMAN RESOURCES (HR)

Planning

HR.1.10 – At one MTF, the clinical supervisor position at the ADAP program had been vacant in excess of two years and the two substance abuse counselors have been performing the responsibilities of the vacant position.

HR.1.30 – At one MTF, following staff interview, data review, and the competence assessment process, it was noted that targets for analyzing indicator had not been set until January 2004. In addition, the annual report to leaders on the aggregation and analysis of date related to staffing effectiveness did not occur until January 2004. The hospital now has set targets and an annual review date for staffing effectiveness.

Orientation, Training, and Education

HR.2.10 – At one MTF, the organization does not have a formal process to assess and document the competence of pharmacists at outpatient clinics following completion of orientation.

MANAGEMENT OF INFORMATION (IM)

Patient-Specific Information

IM.6.10 – At one MTF, during individual patient tracers there were numerous entries, both written and printed, which were illegible both to the surveyor and then hospital staff. In one newborn record, the name on the surgical consent form for a circumcision was entered using the patient's addressograph plate, however the imprint was so faint that the name could not be read. During an individual tracer of a pediatric patient in the Family Practice Clinic it was noted that there was not a complete list of the child's immunizations in the outpatient record.

IM.6.10 – At another MTF, Organization policy states that a narrative discharge summary should be entered in the clinical record at time of discharge. The organization has not defined the parameters of "time of discharge." The discharge summary in 1 of 3 medical records was completed two weeks prior to discharge even though the patient remained in the hospital for the additional time because of complications. The provider provided a one-paragraph addendum to the discharge summary to cover the additional 2 weeks, but it did not cover all pertinent areas in it.

IM.6.10 – At a third MTF, in the review of multiple medical records, signatures and identification of providers were missing. In addition when signatures were present, dates of the signatures were missing.

IM.6.20 – At one MTF, in the Troop Medical Clinic, medical records do not contain all medical information such as visits to sick call. In one physical therapy record, a medical condition was noted; however, there was no documented evidence in the medical record it was acted upon.

IM.6.30 – At one MTF, following a patient record review and staff interview, it was noted that a patient, following a c-section, did not have immediate postoperative progress note entered into the record until

three hours after the operation. The staff remembered that the physician had seen clinic patients (non-emergent) after the section. The patient was transferred to the mother-baby unit prior to the post-operative note being written. Following three patient tracers, record review, and staff interview, it was noted that patients, following c-sections, were being discharged from the post-anesthesia area without an order from the LIP. The order read: Discharge per anesthesia. There was no documentation from anesthesia.
IM.6.40 – At one MTF, review of an open medical record during an individual patient tracer indicated that there was not a problem list. Two of the three medical records for individual ambulatory patient tracers conducted in the primary care clinic did not contain a comprehensive summary list. It was specifically noted that significant past surgical procedures (including vasectomy reversal and hernia repair) and/or past medical diagnoses and conditions (including migraine headaches and cardiovascular disease) had been omitted from these problem summary lists. This finding appears consistent with the organization's own internal audit of medical records, and it was noted that testing on a new electronic summary list is imminent.

SURVEILLANCE, PREVENTION, AND CONTROL OF INFECTION (IC)

Surveillance, Prevention, and Control of Infection

APR 22 – At one MTF, during tours of 4W patient care unit and the Obstetrical clinic it was noted that alcohol based hand rubs were not placed at the entrance of patient rooms, nor at the patient's bedside. During the infection control tracer staff indicated that the alcohol based rubs were only placed in the Emergency Department and in limited clinics.
IC.4.10 – At one MTF, in the Chiropractic clinic, cleaning agents used by the staff had no instruction for use. Staff was not familiar with the length of time the cleaning agent was to remain on the surfaces before removing it. Surgical instrument cleaning was observed. The individual performing the cleaning was not wearing the personal protection apparel as required by organization policy. Further, clean instruments were open and drying on the counter adjacent to the sink where dirty instruments were being cleaned.

MEDICAL STAFF (MS)

Management of Patient Care, Treatment, and Services

MS.2.20 – At one MTF, in one individual patient tracer, the patient's general medical condition was not managed and coordinated by a physician. A young active duty member was admitted from the Podiatry Clinic and managed entirely by a podiatrist with no physician consultation and no other evidence of coordination of his general medical condition with a physician member of the medical staff. An admitting history and physical examination, performed by the admitting podiatrist, was added to the medical some 20 hours after admission, and even then it did not include a complete evaluation of the patient's general medical condition.

Credentialing, Privileging, and Appointment

MS.4.40 – At one MTF, during an individual patient tracer, the medical record demonstrated that an admitting podiatrist appeared to practice outside the scope of his privileges. A young active duty member was admitted from a clinic for wound management and IV antibiotics in connection with an infected wound of the foot following an injury on the job. No physician participated in evaluation and management of the patients overall medical condition. The admitting practitioner's credentials file did not include specific delineated privileges for performing a medical history and physical examination other than for candidates for surgical procedures in ASA class I and II patients.

NURSING (NR)

HOPSPITALS & AMBULATORY CLINICS - 2004
SUMMARY OF JCAHO SUPPLEMENTAL FINDINGS

ETHICS, RIGHTS, AND RESPONSIBILITIES (RI)

PROVISION OF CARE, TREATMENT, AND SERVICES (PC)

Assessment

PC2.20 – At one MTF, in the substance abuse unit the nutritional screening tool lacks criteria for determining high or moderate risk and the corresponding policy fails to address criteria as well.

Additional Standards for Victims of Abuse

PC.3.10 – At one MTF, The organization has a policy on the process for handling cases for identified victims of abuse. The hospital has developed criteria for victims of child abuse, domestic violence, and elder abuse. Criteria need to also be developed for rape and sexual abuse as well as physical assault. In addition to the development of these criteria, the staff needs to be educated on the process used to identify potential victims.

Additional Standard for Patients Being Treated for Addictions

PC.3.110 - At one MTF, in conducting tracer activity in the addition of services the assessment did not contain information about the response to previous treatment and relapse history.

PC.3.120 – At one MTF, the clinical records of two ADAP patients did not contain clinical formulations or conclusions or diagnostic summaries of the data contained in the bio-psychosocial assessments.

Diagnostic Services

PC.3.230 – At one MTF, baseline drug screens are not routinely performed on all ASAP patients, therefore treatment staff may not be aware of illicit drugs that soldiers may be using.

Planning Care, Treatment, and Services

PC.4.10 – At one MTF, during four tracer activities in the substance abuse treatment unit it was noted that care, treatment, and services are planned to ensure that they are appropriate to the patient's needs. Some of the intervention objectives are expressed in global terms and subsequently not measurable. Example was re-establish a spiritual program" and "develop a new peer group". During individual tracer activity on the MedSurg unit, the patient was assessed at risk for falls. This assessment was not included on the plan for care with interventions indicated to prevent falls and potential patient injury. Staff interviews indicated that the hospital is currently working on updating their fall policy and processes.

PC.4.20 – At one MTF, in conducting tracer activity within the addiction program the treatment plans did not include the medications, Antabuse, that the patient was receiving to deal with the addiction.

Pain

PC.8.10 – At one MTF, while the hospital has a comprehensive initial pain assessment, it was noted that documentation of pain reassessment was done inconsistently after pain medication had been administered. Staff indicated that after oral pain medication is administered the patient should be reassessed within one hour. Documentation showed time periods of up to 4 hours before pain reassessment was documented. In some cases medication was re-administered with no documentation that the pain was reassessed after the initial pain medication dose was administered. On one anesthesia record of an obstetrical patient undergoing an epidural, there was no documentation of pain assessment prior to or after the epidural was administered.

Discharge or Transfer

PC.15.20 – At one MTF, one patient in the ED "eloped", ie, left ED prior to being discharged. There was no follow-up or attempted patient contact to insure the patient was seen in the specialty clinic quickly for her complaint. One patient's surgery was cancelled and there were no documentation or discharge instructions for follow-up in the specialty clinic to re-schedule the surgery. There is no consistent process documented to insure follow-up for an unscheduled discharge from an ambulatory setting.

CY 2004 YTD SUMMARY OF FINDINGS: HOPSPITALS / AMBULATORY CLINICS

MEDICATION MANAGEMENT (MM)

Patient-Specific Information

MM.1.10 – At one MTF, in reviewing the record of a patient being seen in Same-Day Surgery and the Outpatient Physical Therapy Department, it was noted that the patient had an allergy to Amoxicillin. Yet this important information had not entered into the automated drug profile system maintained by the hospital pharmacy.

Storage

MM.2.20 – At one MTF, following staff review and unit tour, it was found that the refrigerator at the Ft. McClellan Troop Medical Clinic, was not monitored when the clinic was not opened. This refrigerator contained vaccines and medications, which required a constant temperature. This situation reflects a lack of good process design, particularly related to patient safety.

MM.2.30 - At one MTF, following a patient tracer, staff interview, and tour observations, it was noted that Vecuronium had not been replaced in the stock levels. This medication is used for rapid sequence intubation in the ICU.

Ordering and Transcribing

MM.3.20 – At one MTF, unclear orders for the treatment of nausea were found in printed postpartum orders. The orders were: Reglan 10mg IVPB x 1 PRN nausea and Phenerrgan 12.5 mg IVP x 1 PRN nausea. The nurse indicated she would have to call the physician in order to get further clarification before treating the patient.

IMPROVING ORGANIZATION PERFORMANCE (PI)

Data Collection

PI.1.10 – At one MTF, although the hospital routinely surveys patients about their perceptions of safety the responses do not reflect an understanding of clinical safety. The hospital had not provided pertinent context for questions regarding safety. This practice reflects lack of good process design, particularly related to patient safety.

Aggregation/Analysis

PI.2.10 – At one MTF, Review of medication management data based on near misses indicates that there were 374 incidents, which occurred from January 02 – December 03. Only 20 of these medication near misses were identified as to the type of errors. Those which were reported, were only categorized as dispensing errors and monitoring errors, the dispensing errors were 11 wrong medication form errors, 4 similar drug name errors, and 2 inadequate training errors. The monitoring errors were reported as 2 ADR from no known drug allergy patients and 1 ADR from known same class drug allergy patient. The other 354 were not categorized. No other analysis has been completed. In addition the organization reported a total of 25 falls from January 02 – December 03, however, there is no information as to the analysis of this data.

LEADERSHIP (LD)

Planning, Designing and Providing Services

LD.3.50 – At one MTF, the organization has had a consultation tracking process for the active duty patients that captures appointment making, completion of the consultation, and return of the completed written consultation to the referring provider. However, this system has not been previously able to capture missed appointments for the dependent/retired patient. Commencing July 1, 2004, a new appointment system was implemented that will correct this issue.

Improving Safety and Quality of Care

LD.4.70 – At one MTF, the organization has implemented the “time-out” for operative and invasive procedures. Compliance data is available for the OR areas. For areas outside of the OR the “time-out” is documented, however, the data has not been collected, aggregated or analyzed to determine compliance.

CY 2004 YTD SUMMARY OF FINDINGS: HOPSPITALS / AMBULATORY CLINICS

MANAGEMENT OF THE ENVIRONMENT OF CARE (EC)

Planning and Implementation Activities

EC.1.10 – At one MTF, following staff interview and tour observations, it was noted that oxygen cylinders were being stored with no means of stability at the Ft. McClellan Troop Medical Clinic. The clinic's hydroculator temperature was not being monitored. A more timely analysis of a sprinkler recall issue could have resulted in more targeted and timely remediation addressing for example, higher hazard areas where recalled sprinklers are located, such as in spaces that require a one hour fire rating or greater. These situations do not reflect good process design, particularly related to patient safety and meeting staff needs.

EC.1.30 – At one MTF, following a patient tracer, policy review, and record review, it was noted that the medical staff had not developed criteria for when psychiatric patients were allowed to smoke. The Command Memorandum #29 discussed when requests for exceptions however, the exception was for those patients other than behavioral health patients. The Memorandum from the Department of Behavioral Health regarding the Command Memorandum #29 did not specify criteria, but noted that "depriving psychiatric patients of the ability to smoke results in more behavioral problems and emotional distress for them." This situation reflects a lack of good patient design, particularly related to patient safety.

MANAGEMENT OF HUMAN RESOURCES (HR)

Planning

HR.1.30 – At one MTF, he hospital's selection of direct and indirect caregivers for staffing effectiveness is focused in nursing services with one exception – pharmacy. The direct and indirect caregivers include RNs, LPNs, NAs, and pharmacy staff. Other disciplines/category of staff that may impact staffing were not included in the data collection and analysis. For example; unit clerks, housekeeping staff, phlebotomist, transporters, dietician, and physical therapists.

MANAGEMENT OF INFORMATION (IM)

Information Management Process

IM.3.10 – At one MTF, the list of abbreviations, acronyms, and symbols not to use was in compliance with Joint Commission requirements and was being expanded. There was an approved list available, but it was noted in several medical records that abbreviations were being used by caregivers which were not on this list.

Information-Based Decision Making

IM.4.10 - At one MTF, the hospital uses antibiotics before surgery in various cases, however, it apparently does not measure the timeliness of administration to know if best practice is achieved. This practice reflects a lack of good process design, particularly related to use of performance improvement.

Patient-Specific Information

IM.6.40 – At one MTF, during an individual tracer in the Family Practice Clinic, it was noted that the summary list for the patient only contained the name of two medications. The dosage, frequency and date ordered were not on the list. The patient's diagnosis of ADHD was not on the list, nor were allergies indicated. In addition, the record did not contain a complete list of the child's immunizations. On review of additional records it was noted that in three of four records the summary list was incomplete. In several cases when entries were made they were undated. One summary list indicated that the patient was on no medication, but in another section of the summary list it indicated that the patient was on Ritalin. Neither entry was dated.

IM.6.40 – At one MTF, two out of four medical record summary lists reviewed at the Camp Humphreys Primary Care Unit lacked the required current and complete listing of medications ordered for the patient.

IM.6.40 – At one MTF, in two instances, the summary list had not been completed or incomplete.

CY 2004 YTD SUMMARY OF FINDINGS: HOPSPITALS / AMBULATORY CLINICS

SURVEILLANCE, PREVENTION, AND CONTROL OF INFECTION (IC)

MEDICAL STAFF (MS)

Credentialing, Privileging, and Appointment

MS.4.20 – At one MTF, discussion with the staff and review of a small sample of credentials files demonstrated that relevant practitioner specific performance data was considered at the time of renewal or revision of privileges, but that aggregate data was not generally available for comparison.

MS.4.20 – At one MTF, in September of 2003 it was discovered that the previous credentials coordinator had not completed credentials files as required. Renewal of privileges had not been appropriately carried out on four physicians and five allied providers. The coordinator was immediately terminated and all files were corrected at that time. Files of three of the effected providers were reviewed during the survey. Contact with standards interpretation at the Joint Commission was made during the survey. A copy of the hospitals explanation of the problem and the solution that they used at the time is enclosed.

NURSING (NR)